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Experience Focussed Counselling with Voice Hearers: Towards A Trans-Diagnostic Key to Understanding Past and Current Distress. A Thematic Enquiry.

Running title: EFC as trans-diagnostic key to understanding distress

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**Authorship declaration:** Joachim Schnackenberg co-designed the study, undertook data collection and drafted the manuscript. Colin Martin co-designed the study, supervised the project and checked the text for accuracy; Mick Fleming supervised the project and checked the text for accuracy; Helen Walker supervised the completion of the project and checked the text for accuracy.

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funded PhD research degree at the University of the West of Scotland. He is a trainer at the efc Institute, specialising in the provision of training and supervision in Experience Focussed Counselling, and no fees were received for his part in the provision of EFC training and supervision during the study. Employment of Joachim Schnackenberg by the Stiftung Diakoniewerk Kropp & St Ansgar gGmbH, Kropp, who partook in the study, was offered and accepted following the completion of the study. No financial gain was expected. The authors declare that they have no conflict of interest.

## ***Abstract***

As it is increasingly evident that distressing voices can be linked to traumatic events across diagnoses, there is a need for new transdiagnostic interventions for persons with voice hearing related distress. Twenty-five interviews with voice hearers and mental health professionals explored the trans-diagnostic suitability of Experience Focussed Counselling (EFC) compared to Treatment As Usual. An Applied Thematic Analysis was used. Themes identified were: intervention applicability; impact of regular treatment before study; impact of EFC process; process of working with voices; impact of regular treatment during study; views on treatment or approach. The EFC focus was considered helpful across diagnoses. The findings support EFC as a transdiagnostic intervention.

**Keywords:** Experience Focussed Counselling (EFC); Hearing Voices Movement (HVM); Making Sense of Voices; psychosis; schizophrenia; trans diagnostic intervention.

## **Introduction**

A critical discourse has challenged the purported diagnosis-specific characteristics of hearing voices (Aleman and Laroi 2008), identified strong correlations between trauma and voices across diagnoses (McCarthy-Jones and Longden 2015) and suggests a continuum with the normal population instead (van Os et al. 2009). A symptom-specific, transdiagnostic aetiological and intervention focus might therefore advance the current limitations of diagnosis informed interventions (Bentall 2009), as atypical antipsychotics appear to show some small positive effects for only 18% (Leucht et al. 2009) and effect sizes of Cognitive Behavioural Therapy for Psychosis (CBTp) remain low to medium (Wykes et al. 2008). Some examples of aetiological investigations have focussed on levels of paranoia related to insight and levels of depression (Drake et al. 2004), hasty decision making in persecutory delusions (Corcoran et al. 2008), and on impairments in metacognitive abilities in at-risk of psychosis mental states (Barkus et al. 2010). A recent meta-analytic review, which concluded childhood adversities substantially increased the risk of psychosis, also indicated the need to improve understanding of possible mechanisms between childhood adversities and various presentations of mental ill-health or psychiatric disorder (Varese et al. 2012). Interestingly, the Hearing Voices Movement (HVM) has always focussed on voice hearing related distress across diagnoses (Corstens and Longden, 2013) and suggests a contextual, often traumatic, sociobiographical and normalising focus instead (Corstens et al. 2014).

The individualised approach of the HVM, Making Sense of Voices aka Experience Focussed Counselling (EFC) as it is known within German-speaking countries (Romme and Escher 2013), therefore proposes a unique experience-focussed person-specific approach, which uses respective voice hearing distress levels beyond diagnoses as a criterion for engagement (Schnackenberg and Burr 2017). This goes beyond the framework of psychotic disorders as applied in Cognitive Behaviour Therapy in Psychosis (Steel 2017). Importantly, like Open Dialogue (Runte 2015), it also uses a systemic understanding. However, it extends this by explicitly including voices as important contributors in a voice hearer's network.

EFC thus proposes the alternative of focussing not on diagnoses but on the nature, content, life context of, and relationship to, hearing voices to be central to understanding life context related and current distress experiences (Romme and Escher 2008). For example, a person may be agitated and speak about being possessed as a way of reacting to, and subjectively making sense of, a negatively perceived voice.

Conventionally, a person might thus be classified with psychomotor agitation, delusional thinking, hallucinatory experiences and thought disorder as part of a diagnosed psychosis presentation. Conversely, a person may react to overwhelming voice hearing by withdrawing socially or feeling less able to care for him/herself. Diagnostically this might normally lead to negative symptom classifications like social withdrawal or self-neglect as part of a schizophrenia diagnosis. He/she may also fear going out since the voice forbids this, threatening very damaging consequences to the voice hearer or others, thus leading to depression or anxiety presentations. Within an EFC understanding in all the above cases the voices may, however, be both pointers at, and an attempt to, coming to terms with unresolved life-related conflicts, a view which originally appeared to be more unique to the HVM approach (Romme and Escher 2010). That is to say, a demeaning voice may, for example, resemble a demeaning bully from the past. Such understanding may become clear as part of a voice hearer led sense making EFC process. It may thus be treated as an invitation to come to terms with the past bullying experience and its possible negative social implications in the present, such as a potential fear of setting boundaries or speaking up. This hypothesis of an individual's distress being in part explained by the reaction to the voices and potential unresolved life conflicts can help to comprehend experiences beyond conventional psychiatric diagnoses (Romme and Escher 2000) and has found its way into the common practice of EFC. Within EFC voices are thus considered a potential source of knowledge and not expressions of a sick mind (Schnackenberg and Martin 2014). They can be utilised as recovery facilitating resources within a supportive voice hearer led process across different diagnoses (Romme and Escher 2000). The main EFC tools used are the Maastricht (voices) Interview, Report, and Construct. These are designed to help answer the question who

and what the voices represent and whether they express something important about the voice hearers' lives' contexts, such as unresolved life conflicts (Romme and Escher 2008).

Recently, the publication of the Power Threat Meaning Framework by the British Psychological Society (Johnstone & Boyle, 2018) has echoed this view. Even the National Institute of Mental Health, in a development of their criticism of the Diagnostic and Statistical Manual – Fifth Edition (DSM-V), suggested a trans-diagnostic symptom approach to increase validity (Insel, 2013).

Importantly, there is a lack of formal qualitative research exploring the value of such experience-focussed and transdiagnostic claims of EFC, which this study aimed to address.

## **Methodology**

This was a qualitative enquiry as part of an overall mixed-methods study design.

### ***Design***

This article represented one of several lines of a qualitative enquiry using semi-structured interviews, which was conducted following the completion of a quantitative pilot randomised controlled intervention study (*reference to be included on acceptance of manuscript for publication*). An inductive explanatory model approach of Applied Thematic Analysis (ATA) was chosen for the qualitative study to suit this overall mixed-methods approach (Guest et al. 2012). The quantitative part of the mixed-methods study had adopted voice hearing distress levels rather than diagnoses as inclusion criteria. Quantitative measures included scales of voice hearing distress, general psychopathology, psychosis distress, anxiety, depression, recovery, quality of life, insight and locus of control. The research aim and question of this qualitative enquiry was to understand whether MHP (mental health professional(s)) and voice hearers, who had either taken part in an EFC or Treatment As Usual (TAU) intervention over a period of 10 months as part of the quantitative part of the mixed-methods study, viewed EFC to be applicable in understanding and working with past and current distress independently of diagnoses when compared to TAU. The conducting and analysis of this qualitative arm of the research was done by the lead author of this paper. Following the completion of the qualitative interviews, a process of transcription, structural and content coding ensued, which set the basis for the reducing and comparing of the data in preparation for an analysis, which linked the results with the research aim.

### ***Method of recruitment***

On completion of the 44-week pilot randomised intervention study the first author reminded MHP, who had taken part in the pilot study either as EFC or TAU interventionists, that there was an option for them and the voice hearers to take part in separate post-intervention qualitative interviews. These would offer interviewees an opportunity to reflect on their experience with either EFC or TAU. The MHP proceeded to ask the voice hearers, who had taken part in the intervention study, if they wanted to be interviewed. If interest in an interview was expressed either by the voice hearer or the MHP, they were contacted by the first author and again reminded of the voluntary nature of participation. A suitable time for a face-to-face or phone contact was consequently arranged, depending on preferences by the interviewee and logistics. Importantly, the option of taking part in a qualitative interview process had been part of the information sheet for the overall mixed-methods study (which included the pilot randomised intervention study) and for which both MHP and voice hearers had signed voluntary informed consent forms.

### ***Participants***

Participating voice hearers and MHP (i.e. mental health nurses, social workers, psychologists and pedagogues needed a basic professional qualification, work in a psychiatry related setting, and have a voluntary voice hearer off their caseload randomised to the study), recruited from two psychiatric services in Germany, reflected on their respective experiences of either EFC or TAU (interventions explained below) on completion of a 44-week pilot randomised controlled intervention study. Most available MHP and voice hearers agreed to take part, meaning only  $n=2$  TAU voice hearers (did not want to take part),  $n=1$  EFC voice hearer (moved away), and  $n=1$  EFC MHP (on long-term sick leave) were not included. This meant a total of  $n=9$  EFC voice hearers plus their respective  $n=9$  MHP were interviewed. A total of  $n=7$  TAU interviews pertained to  $n=5$  voice hearers. More specifically, two TAU voice hearers and their respective two MHP, one additional TAU voice hearer and two additional TAU MHP were interviewed. Voice hearer study inclusion criteria included a minimum voice hearing distress level and not a diagnosis of psychosis, as part of a need for care criteria (Bak et al. 2003), at  $\geq 4$  on the Brief Psychiatric Rating Scale – Expanded Version 4.0) (Lukoff et al. 1986) hallucinations item. All voice hearers were on antipsychotic treatments and long-term psychiatric support at the beginning of the intervention.

### ***Interventions***

Both the intervention (EFC) and control (TAU) group had continued to access the range of usual psychosocial and psychiatric support during the initial 10-month pilot randomised intervention study. The

key difference between the EFC and TAU group had therefore been in the respective focus of one-to-one talking support. EFC providing MHP had been trained in the theoretical and practical application of the Maastricht Interview/Report/Construct, as well as EFC specific coping strategies (see below), by the EFC Institute during 3 x 2 days of training during the first 6-months of the study. They also had on-going access to EFC supervision via the first author of this article. All but one EFC group voice hearer also wanted to opt in to take part in some or all of the EFC training.

As indicated above, the focus of this paper was a qualitative reflective exploration of the relative value of EFC and TAU as trans-diagnostic interventions as experienced by MHP and voice hearers who had previously taken part in a quantitative intervention study comparing these two groups.

### ***EFC***

In the initial quantitative pilot intervention study, EFC group participants had been asked to focus on the sequential use of the Maastricht Interview, Report and Construct alongside HVM recognised coping strategies, such as learning to talk to voices in a boundaried and constructive manner (Romme and Escher 2008; 2010; Corstens et al 2012; Corstens and Longden 2013) during normal one-to-one times.

Importantly, the Maastricht Interview offers a structured voice and life context specific exploration of past and current voices distress within the person's life context. It is not unusual for the process of engaging with the Maastricht Interview to have a voice hearing distress alleviating impact. The Report summarises the information and the Construct offers a dialogical forum within which the questions *who* and *what* the voices might represent within the person's life context can be worked out. The Construct may highlight areas of socioemotional conflict in need of addressing. The whole process should be as voice hearer led as possible and the number of total sessions required also depends on the respective needs and abilities of both voice hearers and MHP.

### ***TAU***

TAU participants had been asked to engage in supportive one-to-one time as usual and in line with a pre-study existing pathology paradigm, which had included a focus on distraction techniques, reality orientation and education on the purported psychopathological nature of voices. Access to work related and daily living skills rehabilitative support continued.

### ***Preparation and data collection process***



Two experts-by-training (Romme and Escher) and one recovered expert-by-experience (and trainer in EFC) had helped develop the interview schedule. A trial run with two study-criteria meeting voice hearers and one MHP ensured comprehension levels and a recommended time of no more than 75 minutes (Guest et al. 2012). Actual interviews varied between 30 – 95 minutes.

### ***Interview schedule***

The semi-structured interview (available at request from the first author of this article) was designed to allow some comparability with the quantitative part of the study as part of the overall mixed-methods approach. Apart from four additional questions for MHP, the interview schedule was essentially the same for MHP and voice hearers from the EFC and the TAU group, though it was group specifically worded. Both voice hearers and MHP were asked to reflect on their perspective of how EFC or TAU was applicable for themselves (if they were a voice hearer) or the voice hearer they had worked with (if they were a MHP). Additional elements of the interview schedule, which pertained to questions on trauma and recovery were considered in separate papers. Questions specific to this paper included: Did you feel in control of your voice hearing experience before the study?; What did you like about the process of working with voices?; What hindered or facilitated the process?; Did you (only asked in interviews with MHP) feel able to work more than, less than, or in the same way recovery focussed as before? Prompters were designed for interviewees to focus and clarify their responses.

### ***Conducting of the interview***

The only interviewer (first author of this article) encouraged interviewees to select a setting of their choice to ensure as open and free an exchange as possible (Moriarty 2011). The interviewer (an EFC trainer/practitioner) was very familiar with the topic and tried to create a comfortable atmosphere where interviewees felt able to speak freely. Interviews took place at home and in work settings and lasted between 30 – 90 minutes. Participants were given opportunities to summarise and provided with verbal summaries by the interviewer and a chance to correct these at the end of the interview process. A review of these summary sections of the interviews did not indicate any need to change the transcriptions, thus increasing the confidence in the analysis process (Guest et al. 2012). A debriefing note tool was applied (Guest et al. 2012) following each interview, to potentially improve on style in subsequent interviews.

### ***Transcription process***

Simple transcription guidelines were applied (Dresing et al. 2012) in the verbatim transcription process.

### ***Development of content codes***

The development of content codes followed guidelines by Guest et al. (2012) and included the discovery and winnowing of themes, followed by the creation of a codebook and the linking of themes to theoretical models. Specifically, following familiarisation with all texts, content themes were identified and defined as part of a continual process until code creation and code application saturation had been achieved after three coding applications. APA guidelines and an iterative (Guest et al. 2012) circular, surface-level semantic, combined with a latent, approach (Braun and Clarke 2006) helped to answer the research question, that is, ‘Is it possible to use EFC with voice hearers irrespective of their diagnosis?’ The on-going process of code definition revision saw, for example, “...voice hearer ... relationship with the voices has got worse...” change to “...voice hearer ... relationship with the voices has got worse ..., as evidenced by feeling more distressed by them”. MHP and voice hearer interviews were coded separately though with the same kind of codes applied, as both focussed on the experience of the voice hearer.

### ***Inter-rater reliability of coding categories***

As the interviews were part of a PhD project all of the coding and analysis were conducted independently by the first author. The co-authors of this paper checked the text for accuracy and supervised the project.

### ***Data analysis preparation***

274342 words of overall typed data corpus were reduced and compared to facilitate the analysis. A combination of code frequency summaries and code-by-stakeholder group matrices (Guest et al. 2012) using relative code frequencies displayed in tabular form indicated whether a code had been endorsed at all (tables available at request from the first author).

All interviewees were asked at the end of interview and confirmed that they had felt able to say what they had wanted. An analysis of the structural codebook showed a very good 98% to 100% question and answer saturation rate, whilst keeping potential areas of bias to a minimum level (unpublished results).

### ***Ethical approval and consent***

University of the West of Scotland ethics committee approval and local ethical approvals were gained between June 2011 and December 2012. A half-day information session for MHP with the first author

prior to the mixed-methods study led to interested and eligible voice hearers off MHP caseloads and interested MHP being asked to read through a study information sheet and discuss any questions with the first author prior to signing a written voluntary consent form. Informed consent was obtained from all participants included in the study. Participants interested in the qualitative interviews were reminded again of their voluntary participation prior to the interviews. Participating voice hearers and MHP were allocated anonymised names to preserve confidentiality. There were also no known conflicts of interest.

## **Results**

### ***Description of voice hearers***

Diagnosis related information of voice hearers, age, and length of psychiatric contact were largely comparable between groups prior to the mixed-methods study (tables 1 & 2). None were in employment; five of nine in the EFC group and three of five in the TAU group were living in 24 hour supported residential settings. One EFC and TAU voice hearer respectively were living semi-independently. Three EFC voice hearers and one TAU voice hearer were living independently with supportive visits. Most voice hearers were of German origin. Male and female ratio of voice hearers was similar.

**Table 1 – about here - Voice hearers’ demographics and characteristics in TAU group interviews**

**Table 2 – about here - Voice hearers’ demographics and characteristics in EFC group interviews**

Diagnoses were mostly from within the psychosis spectrum range though the EFC group also included one EUPD, one DID, one past alcohol dependency, as well as one multiple drug use.

### ***Themes***

Themes were drawn from both MHP and voice hearer interviewees. A final theme map identified five themes pertaining to the research question and overall theme of ‘intervention applicability’ across diagnoses (see figure 1). Each theme consisted of a series of subcodes, which were marked by inverted commas in the following. As all TAU interviewees confirmed that TAU support had not included specific work with a voice hearer’s voices, most of the following quotes are drawn from EFC interviewees.

**Figure 1 – about here**

*Theme 1: impact of regular treatment before study*

In order to understand the potential impact of EFC it was important to gauge how helpful TAU had been prior to the mixed-methods study. About half of the EFC and TAU group interviewees had felt TAU to have been 'generally helpful' for psychiatric distress in the year before the study. However, just over two thirds each had also considered it not to have been helpful in some ways at the same time. Importantly, no interviewee in the TAU group and all but one in the EFC group had felt TAU to not be 'helpful for voice hearing related distress'. However, at the same time over a third of EFC interviewees had seen some general and voices distress specific benefits through TAU before the commencement of the study.

EFC group interviewees attributed this, on balance, more negative assessment of TAU to any potential positive TAU impact having largely been quite short lived.

Mo's professional asked whether the potentially confounding effects of antipsychotic medication, may in fact have worsened his client's chance of recovery.

*... And increase [the antipsychotic medication] a bit more, you know... of course she did suffer anyway.  
... sleeping through it... . That is not a life. ... she has spent ... a big part of that time [recent years] in  
bed. [Mo's professional].*

*Theme 2: impact of EFC process*

All EFC group voice hearers had completed the Interview, six the Report, and three the Construct. 4/9

EFC MHP attributed stumbling blocks in progress down to respective degrees of internal (i.e. avoidance by the voice hearer) and external (i.e. professional time available) resources available to the voice hearer.

The completion of the Construct opened up life-context related sociobiographical areas in need of intervention, such as the emotional processing of a sexual assault, as Gail's professional explained.

*And ... now ...is ... the phase, where the Construct would have to be worked through intensively. ... with  
the rape. ..., which she has been trying to suppress for many years, ... And she is finding that difficult.  
[Gail's professional]*

The benefits of persistence with EFC work and the Construct were well explained by client Vince.

*I do have the feeling ... how I have not had for a long time, you know. That I nearly did cry, didn't I.  
... Well in that moment [after the completion of the construct], it was relief for me. Because ... all of  
the things that had happened, you know. I had bottled it [bullying, emotional abuse] all up... .  
[Client Vince]*

*Theme 3: process of working with voices*

A series of subcodes (marked in inverted commas) exploring subthemes, formulated in *italics* at the beginning of a paragraph, illuminated the process of working with voices.

*What made the process of working with voices difficult?* Voice hearers (two in the EFC and one in the TAU group) identified primarily a sense of not being able to be ‘open’ with non-EFC trained MHP or that no actual process of working on the voices had taken place. The latter point was raised by one voice hearer in the EFC group – even though work had taken place – and two people in the TAU group, where none of the interviewees identified any MHP guided specific work on voices taking place.

The one TAU voice hearer who did actually work on her voices, only started doing so after being told by her psychiatrist, that after several years of trying, antipsychotics were not working for her. She started talking back to them, which gave her a sense of relief. She explained how she told herself:

*“No. I do not fancy that [being made afraid by the voices] any more. .... And if they [the voices] want to kick up a fuss, I am going to the coppers” ... I talk [in a defensive way] to the voices. [Client Paula]*

However, this process of talking to the voices defensively did not help her to identify any clear or even positive meaning for the voices within her life context, nor did it substantially relieve her levels of distress.

EFC client Theo explained the problematisation by non-EFC trained MHP as a hindrance to openness.

*... I am always afraid ... that people will then go on and dramatise again and ... then ... end up calling the psychiatrist again ... And he will then end up wanting to do something with the medication again and so on. I have had bad experiences with that, you know. To express oneself, you know. To express oneself honestly, too, //like, you know.// ... I do not have a problem with X [name of EFC professional]. [Client Theo]*

Nearly half of the EFC MHP, in contrast, felt that voice hearers’ regular ‘avoidance’ (even prior to the study) and a ‘lack of their own time’ particularly had made it more difficult to engage in the process of working with voices. About a third of EFC MHP also felt that voice hearers seemed to ‘not see connections between the voices and their lives’ contexts’ even though it had been obvious to the MHP themselves.

Importantly, ‘formal thought disorder’ and ‘fear of engaging with the working with voices process’, as well as the approach being ‘new’ had only been endorsed by one and two MHP respectively as potential stumbling blocks.

*Helpful techniques* particularly endorsed had been limited to EFC tools, such as the ‘Maastricht Interview’, the ‘Maastricht Construct’ and ‘peer support’.

The value of informal peer support, though not part of the individualised EFC intervention study set up, was endorsed by four out of nine voice hearers. Client Gail explained it well.

*Gail: Well ... I do have a fellow resident here .... Who does also hear voices. And I do have a good connection with her. ...*

*Interviewer: How do you like it, when you talk with her about it?*

*Gail: Relieving. ....*

*Interviewer: And she?*

*Gail: The same. Yes. [Client Gail]*

The most commonly identified (by four out of nine EFC MHP) helpful tools were the Maastricht Interview and Construct.

*Well, I thought the Maastricht Interview was the most helpful. ... it is so structured. It really did ... provide a fundamental overview of the whole history of this voice hearer... and well, I did think it was brilliant. [Ben’s professional]*

*[I] think it [the construct] was very emotional for him. And may be he can better understand why ... he is so restrained, why he is such ... [an] emotionless person on the outside. .... //I think he did// feel relief. Yes. And no longer... such a failure. [Vince’s professional]*

*Helpful processes* were again primarily identified by EFC group interviewees. Only one voice hearer in the TAU group had decided to start working on the voices independently, as outlined before.

Seven out of nine EFC voice hearers and all nine EFC MHP felt that ‘being able to speak openly about voices and related concerns’ had been most helpful. Seven EFC MHP felt that the ‘structure provided in making sense of the voices in relation to the past’ had also been very helpful, echoed by six MHPs’ views

that the ‘structured engagement’ had been important, and four MHP who felt that the ‘collaborative way of working’ in EFC had been particularly helpful.

*.. it has been quite helpful ... you know, to decode the past in more detail. ... there are so many details, which have come up for discussion, which I would never have thought... the talks which I had with her before, they had ... somehow always got stuck on the surface. ... And then somehow one did not know how to continue. ... Now I do at least have a rough plan ... why this has happened to her. [Mo’s professional]*

*Which professional attitudes helped?* A majority of EFC MHP identified their own ability to ‘talk more openly about trauma’ and ‘take the voice hearers more seriously’ as helpful. Almost half of the EFC MHP also felt it was important to be ‘available in crises’ and a third of voice hearers felt it helped that their professional seemed to be ‘able to understand’ them.

EFC client Gail highlighted these attitudes and their positive impact well.

*Like I said, that ... I dare to do more. That I ...am taken seriously here. ...That I am learning to deal with the voices ...in the evenings, too. I still need to work on that though. [Client Gail]*

*Which voice hearers’ attitudes helped?* A third of voice hearers in the EFC and TAU group felt it was particularly helpful to have ‘more hope of recovery’, although in both groups this hope was associated with the EFC approach. Specifically, in the case of the TAU client, this was hope associated with post-study engagement with the EFC approach. A third of MHP felt that voice hearers’ ‘taking charge of their own recovery’ and becoming ‘less avoidant’ in relation to the voices work had also been helpful.

#### *Theme 4: impact of regular treatment during study*

There had been a strong rehabilitation focus in the TAU interventions, to which both EFC and the TAU group had access, as the main difference between the groups was the focus of one-to-one times. These included various group and work-related activities alongside regular reviews and the one-to-one times. However, the TAU aspect alone had clearly not succeeded in reducing voice hearing distress levels significantly. Only two voice hearers in the EFC group therefore felt that the TAU aspects of the intervention had had a ‘positive impact’, with only one professional in the TAU group feeling that TAU had been both ‘positive and negative’.

*Theme 5: views on treatment or approach*

In contrast to perspectives on TAU, all EFC group interviewees had had an ‘overall positive impression of EFC’, none a purely negative, and only one voice hearer felt it was both ‘positive and negative’. A third of voice hearers and seven out of nine MHP felt that ‘supervision’ also represented an important aspect of EFC.

This positive endorsement of EFC was further echoed by none of the MHPs’ expressing any limitations of EFC applicability to specific diagnoses, as they had also applied it to non-study voice hearers with varying diagnoses, which included some non-psychosis primary diagnoses. Both voice hearers and MHP also felt that even if it had been ‘stressful’ to engage in the EFC process at times, it had ‘not’ been ‘too stressful’ to work with. Not surprisingly, 15/18 EFC interviewees felt that life for EFC group voice hearers had ‘improved overall’, whereas this was only felt to be the case for two of the TAU group voice hearers. Importantly, life improvements in the TAU group had been attributed to either the client’s own efforts or to the support of family and friends only. None of the interviewees felt that life had got worse. EFC client Theo highlighted the freedom and space in his mind that had opened up as the voice hearing distress reduced significantly. Even if not always easy, he was enjoying taking on more responsibility, having moved out of 24-hour supported care and living in an independent flat with minimal support.

*Well ... my thinking no longer circles ... only around ... that I have to push myself with coffee and so on [as he had been doing prior to EFC work]. But ... I [now] do have to think about what to prepare for lunch. ... about what I am going to shop. ... that is a lot more independence //really.// ... //If I am// honest, I used to think ... a lot ... with my illness... that I would grow dependent on care ... And initially I was thinking, “You have got so used to living here ... But... then I was there for the second time [viewing of potential new independent flat] ... And then I could imagine it all ... [to move out]. [Client Theo]*

*Overall impact of EFC on staff views* – as a result of being ‘trained in EFC’ and ‘applying it in practice’, all EFC group MHP particularly noticed a ‘change in attitude’ of now seeing voices and related distress as being connected to a person’s life context. They also felt that voices were ‘central to understanding overall mental distress’, as they felt that voices also ‘impacted’ on other symptom experiences. Importantly, a process of sensitisation to the impact of voices on voice hearers’ behaviour had also taken place, as most now also felt that they could ‘see’ or notice ‘voices’ where they had not done so before.



For some MHP, this meant that overall levels of ‘understanding’ voice hearers’ presentations and experiences improved simply by understanding the reaction of voice hearers to voices.

*Well the understandability has changed for me. ...That is, I think in the past one would ... not really go into it. And now ... "...what kind of voice is it?" ... "How long have they been there?" Or to simply look differently then on the voice.*

*Interviewer: ...And that does make her general behaviour more understandable for you on the whole?*

*Xenia's professional: Yes. Of course. [Xenia's professional]*

*Overall impact of EFC on staff practice* – importantly, there had also been an impact on EFC MHPs’ practice, with all now feeling more ‘able and equipped to work in a recovery focussed way’, and almost all but one feeling that they were now ‘looking at voice hearers differently’ with a greater ability to provide ‘hope’ and ‘motivation’ to work towards ‘recovery’. A majority also felt that they had been able to ‘inspire non-EFC trained staff’ to work in more non-medical ways, too, and just over half felt that they were now more ‘open to talk about trauma’ and that the whole ‘team’s philosophy’ had therefore been changed to using an EFC approach.

Amy’s professional pointed out how the overall change in both EFC trained and non-EFC trained MHP did necessitate a change process by staff, too, which was not necessarily only easy for them.

*... And at the same time we were changing, too. So that many came and started talking about the voices.*

*That is something one has to find a way of living it out in the team first of all, too. ... The kind of things they were suddenly telling us. [Amy's professional]*

## **Discussion**

It is clear from the findings of this first qualitative enquiry into the transdiagnostic relevance of EFC, that EFC had been universally endorsed by most EFC exposed MHP and voice hearers alike as being a positive, not too stressful experience, applicable across diagnoses, with the potential to improve voice hearers’ lives overall. In contrast, progress in the TAU group had been attributed to non-TAU intervention specific factors, such as the voice hearer’s own motivation or the positive supportive impact of family, as no voice-specific work had been provided by TAU. It is not surprising therefore that no additional benefits had been associated with TAU, such as promoting a greater understanding of TAU voice hearers’ past or current distress. Importantly, the feedback by EFC trained MHP suggested that the application of EFC necessitated a real paradigm shift in attitude and practice by the EFC group MHP in

particular to understand voices as both biographically meaningful and important to actively work with. This confirms reflections in the recovery literature more generally (Glover 2005) and in the HVM literature (Romme 2009a; 2009b) in particular. A simple three-level EFC training, regular offer of supervision and their own changed practice experience seemed to not only convince EFC MHP and voice hearer study participants, but also those MHP and voice hearers outside of the study of the merits of EFC. In fact, both research sites expressed interest in rolling out EFC across their organisations post study conclusion. The EFC focus on voices as non-pathological, understandable experiences, provided an entirely new approach to voices as potential sources of knowledge about unresolved life context issues and the nature of currently distressing experiences (Schnackenberg and Martin 2014). This opened up new ways of engaging in trauma, voices, and emotion-related acceptance work independently of diagnoses, which these newly trained EFC MHP and voice hearers had previously not known to be possible.

### ***Limitations and strengths***

This study was limited by the small number of non-psychotic disorder diagnosed voice hearers to be able to confirm EFC's applicability across diagnoses, necessitating future studies to address this. However, EFC MHP in this study did not express any limitations in applying EFC across diagnoses and did indeed feel benefits from applying EFC with non-psychosis diagnosed voice hearers outside of the study set up. Validity of the findings was further enhanced by using several sources of information, i.e. voice hearers and MHP from both the EFC and TAU group from the quantitative pilot randomised intervention arm of the overall mixed-methods study (Guest et al. 2012). The cohort size and the small number of EFC participants ( $n=3$ ) completing the construct were additional limitations. The length of the quantitative intervention study (ten months) and the retrospective nature of the interviews likely allowed for a more balanced perspective, thus addressing any potential question of a susceptibility to EFC born out of potential dissatisfaction with TAU.

### ***Implications for Mental Health Practice***

One of the strengths highlighted in this qualitative study was the endorsement of EFC by frontline staff, like social workers and nurses, in routine settings without the need for prior high level qualifications, such as a trauma therapy or a psychology doctorate qualification. Limited time available confined the extent to which MHP felt able to apply EFC in practice, though not to the extent that they did not feel able to

meaningfully engage in it at all. In this way, concerns about the applicability of artificial research findings in routine settings (Thomas 2015) were addressed, and EFC or comparable country-specific training might thus be suitable for inclusion in the core training of all frontline practitioners. This does not preclude some voice hearers finding access to well-trained trauma-therapists helpful, too.

This qualitative enquiry thus provided evidence for the applicability of EFC in the practice of mental health nurses and other frontline staff in the support of persons diagnosed with psychotic disorder. The inclusion of client Gail in an EFC process (who had been diagnosed with a non-psychotic disorder), the  $n=6$  (table 2) EFC voice hearers who had a non-psychosis secondary diagnosis, the confirmation by practitioners that voices can be made sense of within their lives' contexts, as well as the insights of the HVM (Romme et al. 2009; Corstens et al. 2014) suggest EFC's potential for a transdiagnostic application. In fact, life context is known to play a role in non-psychotic disorders anyway. Such potential transdiagnostic credentials would ideally be confirmed in future studies. This study also points to the primary value of referring to voices as an experience that can be understood as a potentially enlightening source of valuable information about the person's current and past life experiences. Voices could thus be lived with and whether voices are considered to be indicative of any psychopathological concepts, might therefore be a values-based choice rather than an evidence-based one (Johnstone & Boyle, 2018; van Os et al., 2009).

**Ethical approval:** "All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards."

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**Table 1: Voice hearers' demographics and characteristics in TAU group interviews (n=5)**

Characteristic	Results	Voice Hearers
Age in years, mean (s.d.)	43.80 (7.89)	All
Years of continuous psychiatric contact, mean (s.d.)	19.60 (8.62)	All
Primary diagnosis		
<i>Schizophrenia</i>	4	All but Sally
<i>Schizoaffective disorder</i>	1	Sally
Years since main diagnosis, mean (s.d.) (n=4)	19.75 (10.37)	Sally's not traceable
Secondary diagnosis		
<i>Mental and behavioural disorder due to multiple drug use</i>	1	Ian
Years since secondary diagnosis, mean (s.d.)	18 (0)	

Terms explained: Alice, Bertie, Ian, Paula, Sally – voice hearers anonymised for this paper; s.d. – standard deviation.

**Table 2: Voice hearers' demographics and characteristics in EFC group interviews (n=9)**

Characteristic	Results	Voice Hearers
Age in years, mean (s.d.)	43.89 (9.61)	All
Years of continuous psychiatric contact, mean (s.d.)	16.78 (9.81)	All
Primary diagnosis		
<i>Schizophrenia</i>	7	All but Vince & Gail
<i>Schizoaffective disorder</i>	1	Vince
<i>Emotionally unstable personality disorder (EUPD)</i>	1	Gail
Years since main diagnosis, mean (s.d.)	17.44 (6.95)	
Secondary diagnosis		
<i>Schizophrenia</i>	1	Gail
<i>Dissociative identity disorder (DID)</i>	1	Amy
<i>Epilepsy</i>	1	Ben
<i>Mental and behavioural disorder due to multiple drug use</i>	1	Theo
<i>Alcohol dependency</i>	3	Rob, Mo, Vince
Years since secondary diagnosis, mean (s.d.) (n=7)	16.80 (10.28)	Vince and Mo not traceable

Terms explained: Amy, Ben, Gail, Mo, Rob, Theo, Vince, Wendy, Xenia – voice hearers anonymised for this paper; s.d. – standard deviation;



*Figure 1*

